



**Request for Insurance
FEDERAL EMPLOYEES' GROUP LIFE INSURANCE PROGRAM**

CAREFULLY READ INSTRUCTIONS ON OTHER SIDE BEFORE COMPLETING THIS FORM.

TO: OFFICE OF FEDERAL EMPLOYEES' GROUP LIFE INSURANCE

I hereby apply for cancellation of any waiver or declination of life insurance which I previously filed and request insurance under the Federal Employees' Group Life Insurance Program.

Signature of employee (must be signed in the presence of an authorized official of your employing agency or authenticated from official records)

Address (number, street, city, state, ZIP code)

Date

PART A – TO BE COMPLETED BY EMPLOYING AGENCY

1. Full name of employee (Last, first, middle)

2. Date of birth (month, day, year)

3. Title of position

4. Agency in which employed, including bureau or division

5. Location of employment (City and State)

I certify that the signature appearing above is that of the employee named and that the information in Part A, items 1 through 8, has been obtained from and correctly reflects official records.

Name and mailing address of agency (type or print)

• TO:

6. Effective date of employee's last election, waiver, or declination of life insurance coverage (SF 2817)

Month Day Year

7. Will employee be eligible to become insured if this "Request for Insurance" is approved?

☐ Yes ☐ No

8. Has employee had any continuous absence of at least 3 weeks on account of sickness or injury during the past

☐ Yes ☐ No

Signature of certifying agency official

Title

Telephone Number
(including Area Code)

Date

PART B – TO BE COMPLETED BY EMPLOYEE

1A. Have you had any change in health in the past 5 years? Do you need medical advice, study, or treatment?

☐ Yes ☐ No

1B. If "Yes", briefly note details.

2A. Have you sought medical advice or been treated by a clinic, hospital, physician, or healer within the past 5 years?

☐ Yes ☐ No

2B. If "Yes", briefly note dates, reasons, and treatments.

3A. Have you ever been denied life or health insurance, or offered it at additional

☐ Yes ☐ No

3B. If "Yes", briefly note details.

4A. Have you ever had or were you ever told you had the following:

Check One

Yes No

Check One

Yes No

4B. If your answer to any part of question 4(A) is "Yes", briefly state condition, dates, duration, and kind of treatment. Also state names and location of doctors and hospitals.

Chest pain, swollen ankles, or disease of heart or blood vessels?

Unconsciousness, paralysis, epilepsy, or other nervous, muscular, or mental disorder.

High blood pressure?
How high?

Cancer, tumor, polyp, or disease of the blood, spleen, or lymph glands?

Asthma, emphysema, chronic bronchitis or other lung diseases?

Diabetes, tuberculosis, drug habit, or other defect or disease not mentioned herein?

Liver conditions, ulcers, or gastrointestinal (G.I.) conditions?

Biopsy, surgical operation, radiation treatment or medical study of a condition not mentioned herein?

Disease of kidney, bladder, male or female organs, or albumin or sugar in the urine?

The answers I have given in Part B are for the purpose of securing approval of this "Request for Insurance" and I certify that they are true and complete to the best of my knowledge and belief.

Signature of employee (must be signed in presence of examining physician)

Date

PART C – TO BE COMPLETED BY EXAMINING PHYSICIAN

To the Examining Physician

1. This examination is for Federal Employees' Group Life Insurance purposes. **A PRIOR EXAMINATION REPORT IS NOT ACCEPTABLE.**
2. **THE EMPLOYEE IS TO PAY THE FEE FOR THIS EXAMINATION. DO NOT PERFORM ANY SPECIAL EXAMINATIONS OR INCUR ANY UNUSUAL EXPENSE.**
3. Have the employee sign Part B in your presence.
4. Fully complete, sign and date Part C. Unless specific findings are called for, indicate by checkmark whether findings are normal or abnormal and describe any abnormalities in the space provided.
5. Do not return the form to the employee, but mail it to:

Office of Federal Employees' Group Life Insurance
4 East 24th Street
New York, N.Y. 10010

Print employee's full name		M F	Date of birth (mo., day, year)	Fully describe abnormalities noted or any history of abnormality elicited. (If more space is needed, please attach additional sheet.)		
Does examination reveal abnormality of:		Yes	No			
General (movements, strength, stamina, responsiveness, coordination, etc.)?						
Eyes, ears, nose, throat?						
Respiratory system?						
Heart, arteries, or veins? Any murmurs present?						
G.I. system?						
G.U. system?						
Nervous system and reflexes?						
Extremities and skeletal or muscular system?						
Skin and glands?				I certify that Part B was signed in my presence, that I have carefully examined the individual named above and that my complete findings on examination are correctly recorded.		
Height (in feet and inches)		Weight (in pounds)		Signature of examining physician	Date of examination	
Blood Pressure				Address of examining physician, including ZIP code		
Two readings, sitting		Systolic	Diastolic			
diastolic at 5th phase	First reading					If over 96, pulse after 5 minutes
	Second reading					

PART D – TO BE COMPLETED BY OFEGLI

TO THE EMPLOYING AGENCY: The employee named on the reverse side may:

- ☐ Be insured for Basic Life insurance on the first day he or she is in a pay and duty status after the date shown below, or for Option A--Standard and / or Option B--Additional coverage(s) on the first day in a pay and duty status after the date shown below and receipt of "Life Insurance Election" (SF 2817) by employing office. If employee is not in a pay and duty status within 31 days after the date shown below, the authorization of insurance is void; the authorization of optional insurance is void unless he or she is in a pay and duty status and has also returned a SF 2817 showing an election of optional insurance within the 31 day grace period.

- ☐ Not cancel a waiver of insurance coverage or elect optional insurance.

Approving officer	Date of approval
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INSTRUCTIONS**PLEASE READ CAREFULLY BEFORE FILLING OUT THIS FORM. FAILURE TO OBSERVE INSTRUCTIONS MAY RESULT IN DELAY.****TO THE EMPLOYING AGENCY**

1. The employee is eligible to request insurance only if he or she is not otherwise excluded from insurance coverage and if one year has elapsed since the effective date of his or her last waiver or designation.
2. Generally, the employee is eligible to request **increased** Option B--Additional insurance only if one year has elapsed since the effective date of his or her last election affecting the multiples of Option B coverage. However, the employee may request increased Option--B Additional insurance before one year has elapsed if the previous election increased Option B coverage but was limited to the number
3. Have employee sign top part on reverse side of this form, then complete Part A and give the form to the employee.
4. Have employee execute an SF 2817 only after Part D has been approved by OFEGLI and returned to you.
5. Notify the employee of OFEGLI's decision and file the returned form in the employee's OFFICIAL PERSONNEL FOLDER or its equivalent.

TO THE EMPLOYEE

1. Sign the top part on reverse side of the form and have agency complete Part A.
2. Take the form to any medical doctor of your choice. Complete Part B and sign in the presence of the doctor.
3. Have the doctor complete Part C and send the form to OFEGLI. The form must be received by OFEGLI within 60 days of the date of the medical examination.
4. The fee for the medical examination **must** be paid by you directly to the doctor.
5. OFEGLI will notify your agency whether you may be insured and your agency will inform you of the decision.
6. If your request is approved, Basic Life insurance coverage is automatically effective on the first day you are in pay and duty status after the date of approval; Option A-- Standard and / or Option B--Additional, if elected within 31 days of the approval date, are effective the first day you are in pay and duty status after the approval date and have filed a "Life Insurance Election" (SF

PRIVACY ACT STATEMENT--Title 5, U.S. Code, Chapter 87, Life Insurance, authorizes solicitation of this information. The data you furnish will be used by your agency and the Office of Federal Employees' Group Life Insurance to determine your eligibility to receive benefits under the FEGLI Program. This information may be

enforcement agencies when they are investigating a violation or potential violation of the civil or criminal law. Provision of this information is voluntary; however, failure to supply all of the requested information may result in the inability to determine your eligibility under the FEGLI Program.